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Dresden Nuclear Power Station
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March 5, 1992

CWS LTR #92-123

U.S. Nuclear Regulatory Commission
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Washington, D.C. 20555

Licensee Event Report 92-06 , Docket 050237 is being submitted as required by Technical Specification 6.6, NUREG 1022 and 10 CFR 50.73 (a)(2)(i)(B).

L. J. Hermer for 3/9/92
Charles W. Schroeder
Station Manager
Dresden Nuclear Power Station

CWS/cfq

Enclosure

cc: A. Bert Davis, Regional Administrator, Region III
NRC Resident Inspector's Office
File/NRC
File/Numerical

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LICENSEE EVENT REPORT (LER)

Form Rev 2.0

Facility Name (1) Dresden Nuclear Power Station, Unit 3	Docket Number (2) 0 15 10 10 10 12 14 19	Page (3) 1 of 0 5
Title (4) Isolation Condenser Steam Supply Valve MO2-1301-1 Feed Breaker Found Racked Out Due to Personnel Error		

Event Date (5)			LER Number (6)			Report Date (7)			Other Facilities Involved (8)	
Month	Day	Year	Year	Sequential Number	Revision Number	Month	Day	Year	Facility Names	Docket Number(s)
012	11	92	92	01016	010	013	05	92	Dresden Unit 2	0 15 10 10 10 12 13 17

OPERATING MODE (9) POWER LEVEL (10) 0 4 4	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11) <input type="checkbox"/> 20.402(b) <input type="checkbox"/> 20.405(c) <input type="checkbox"/> 50.73(a)(2)(iv) <input type="checkbox"/> 73.71(b) <input type="checkbox"/> 20.405(a)(1)(i) <input type="checkbox"/> 50.36(c)(1) <input type="checkbox"/> 50.73(a)(2)(v) <input type="checkbox"/> 73.71(c) <input type="checkbox"/> 20.405(a)(1)(ii) <input type="checkbox"/> 50.36(c)(2) <input type="checkbox"/> 50.73(a)(2)(vii) <input type="checkbox"/> Other (Specify in Abstract below and in Text) <input checked="" type="checkbox"/> 20.405(a)(1)(iii) <input checked="" type="checkbox"/> 50.73(a)(2)(i) <input type="checkbox"/> 50.73(a)(2)(viii)(A) <input type="checkbox"/> 20.405(a)(1)(iv) <input type="checkbox"/> 50.73(a)(2)(ii) <input type="checkbox"/> 50.73(a)(2)(viii)(B) <input type="checkbox"/> 20.405(a)(1)(v) <input type="checkbox"/> 50.73(a)(2)(iii) <input type="checkbox"/> 50.73(a)(2)(x)
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LICENSEE CONTACT FOR THIS LER (12)

Name Louis M. Kline, Regulatory Assurance Department	TELEPHONE NUMBER
Ext. 2709	AREA CODE 8 1 5 9 4 2 1 -12 19 12 10

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> Yes (If yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO	Expected Submission Date (15) Month Day Year
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 1420 hours on February 11, 1992, while performing required Control Room panel inspections with Unit 2 at 44% power, a Station Control Room Engineer observed that the position indication lamps for the Isolation Condenser Steam Supply inboard isolation valve MO2-1301-1 were not lit. An Operator was immediately dispatched to investigate. The power supply breaker for the valve was found locked in the de-energized position. This breaker manipulation occurred approximately 3 hours prior to discovery, during diagnostic testing of the Unit 3 MO3-1301-1 valve (Unit 3 was in a refuel outage). The Unit 3 alternate feed breaker which should have been de-energized is immediately adjacent to the MO2-1301-1 main feed breaker found incorrectly racked out. This condition did not render the Unit 2 Isolation Condenser inoperable and the redundant isolation valve was operable. Corrective actions included interviewing involved personnel, review of this event with Operations and Electrical Maintenance personnel, a labelling evaluation, training lesson plan enhancements, and procedural improvements. A previous non-reportable event involving an improper Isolation Condenser breaker configuration occurred in 1986.

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TEXT Energy Industry Identification System (EIS) codes are identified in the text as [XX]

PLANT AND SYSTEM IDENTIFICATION:

General Electric - Boiling Water Reactor - 2527 Mwt rated core thermal power

Nuclear Tracking System (NTS) tracking code numbers are identified in the text as (XXX-XXX-XX-XXXX)

EVENT IDENTIFICATION:

Isolation Condenser [BL] Steam Supply Valve M03-1301-1 Feed Breaker Found Racked Out Due to Personnel Error

A. CONDITIONS PRIOR TO EVENT:

Unit: 2 Event Date: 02/11/92 Event Time: 1420 Hours
 Reactor Mode: N Mode Name: Run Power Level: 44%
 Reactor Coolant System (RCS) Pressure: 960 psig

B. DESCRIPTION OF EVENT:

On February 11, 1992 preparations were being made to perform diagnostic testing of Unit 3 valve M03-1301-1 (Isolation Condenser Steam Supply Inboard Isolation Valve). The first part of the diagnostic testing required that test equipment be connected to the subject valve. Prior to the connection of the test equipment to the valve motor operator, the electrical feed to the operator is required to be de-energized.

An Operator, along with an Electrician, went to Motor Control Center (MCC) 38-1 [ED] to de-energize the breaker for Unit 3 M03-1301-1. The breaker was racked out and locked in the OFF position. The Electrician noted at this time that M03-1301-1 could also be electrically fed (alternate feed) from Unit 2. The Operator and the Electrician went to MCC 28-1 [ED], located in Unit 2. The breaker for M03-1301-1 (Isolation Condenser Steam Supply Inboard Isolation Valve Alternate Feed) was racked out and locked in the OFF position.

The valve test team connected the diagnostic test equipment to M03-1301-1. After the diagnostic test equipment had been connected, the electrical feed to M03-1301-1 was restored. The electrical feed was restored by unlocking the breaker handle at MCC 28-1 for M03-1301-1 and racking it in along with unlocking the breaker handle at MCC 38-1 for M03-1301-1, and racking it in.

After the electrical feed had been re-energized for M03-1301-1, diagnostic testing started. The diagnostic test team directed the Unit 3 Control Panel Nuclear Station Operator (NSO) to open and close M03-1301-1 using the Unit 3 Control Board Switch. The Unit 3 NSO cycled M03-1301-1 approximately six times, and during the cycling of M03-1301-1 the test team took data.

During data taking, the test team noted that they were not getting satisfactory data. The test team decided to stop testing and evaluate.

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The test team directed the Operator at approximately 1120 hours to de-energize the feeds to MO3-1301-1. The Operator racked out the breaker on MCC 38-1 for MO3-1301-1 and locked it in the OFF position with a lock provided by the Electrician. The Operator then proceeded to Unit 2 to de-energize the alternate feed for Unit 3 Isolation Condenser Valve MO3-1301-1 on MCC 28-1. At approximately 1135 hours the Operator arrived at MCC 28-1, and incorrectly racked out the breaker for MO2-1301-1 (Unit 2 Isolation Condenser Steam Inlet Inboard Isolation Valve) and locked it in the OFF position. The breakers for MO2-1301-1 and MO3-1301-1 are located side by side on MCC 28-1.

At 1420 hours, while performing required Control Room panel inspections, a Station Control Room Engineer (SRO) observed that the position lamps for MO2-1301-1 were not lit. An Operator was immediately dispatched to MCC 28-1, at which time the main feed breaker for MO2-1301-1 was discovered locked in the de-energized position. This was promptly rectified by unlocking and racking in the main feed breaker for MO2-1301-1.

C. APPARENT CAUSE OF EVENT:

This report is submitted in accordance with 10CFR50.73(a)(2)(i)(b), which requires the reporting of any operation prohibited by the plant's Technical Specifications.

The root cause of this event was personnel error. The Operator did not apply self-checking when he went to Motor Control Center 28-1 in Unit 2 to de-energize the alternate feed breaker for MO3-1301-1.

A contributing factor during this event was the labeling configuration. The labels on the breaker cubicle correctly identified the breaker, but a caution label (which contains the words ALTERNATE FEED) on the same breaker could mislead an Operator into thinking that he is at the alternate feed breaker for MO3-1301-1. With the feed breaker for MO2-1301-1 and MO3-1301-1 side-by-side on Motor Control Center 28-1, this caution label could influence an Operator into selecting the incorrect breaker.

A further contributing factor during this event is procedural deficiency. Dresden Electrical Procedure (DEP) 0040-10 (Votes System Operating Procedure), was being used to perform the diagnostic testing. Review of DEP 0040-10 indicates that enhancements could be made to more clearly identify the required breaker manipulations.

An additional factor that may have contributed to this event could be that the Non-licensed Operator Group could have a knowledge weakness concerning the theory and application of alternate electrical power supplies.

D. SAFETY ANALYSIS OF EVENT:

This event did not render the Isolation Condenser system inoperable because valve MO2-1301-1 was in its normally open position and movement of this valve is not required for Isolation Condenser system initiation. Although the de-energized breaker would have prevented automatic closure of valve MO2-1301-1 had a Primary Containment Group V Isolation signal been received, the redundant isolation valve MO2-1301-2 was operable and would have closed automatically if necessary. Therefore, this event had minimal safety significance.

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E. CORRECTIVE ACTIONS:

Upon discovering that the electrical feed breaker for MO2-1301-1 was de-energized, it was immediately re-energized.

The Assistant Superintendent of Operations has counseled the Operator involved in the event. The Operator was reminded of management expectations concerning self-checking. The Operator was also reminded that when working with Motor Operated Valves that have dual electrical feed breakers, extra care must be taken to insure that the correct feed breaker is identified prior its operation.

Each Shift Engineer reviewed this event with the Operating crew. The following items were discussed:

1. The concept of self-checking to ensure that activities are performed on the correct unit and the importance of proper understanding of equipment with alternate feeds.
2. In-plant operators must communicate to the Nuclear Station Operator prior to moving, racking in, or racking out breakers for valves to be diagnostically tested.
3. The electricians along with operations will put an ID tag on the breaker to be diagnostically tested to ensure the correct breaker is selected prior to any breaker manipulations. This tag will remain on the breaker until testing is complete.
4. The Electricians are the only department that can place and remove Maintenance Safety Locks. When the Electricians place these locks they are expected to verify that the correct breaker is selected.
5. For all Motor Operated Valves with alternate feeds, an independent verification will be performed after diagnostic testing has been completed.

Electrical Maintenance Supervision has reviewed this event with all Electricians. The Electricians were instructed that they are the only ones than can place and remove Maintenance Safety Locks. Also, when they are placing the lock they are to verify that they are on the correct unit and at the proper component.

A request has been made (CWS LTR #92-104) for the Corporate Engineering Design and Support Group to review and evaluate potential enhancements to the labeling and color coding for dual electrical feed breakers has been issued. After the Corporate Engineering and Support Group completes their evaluation, the Station will review and implement the appropriate recommendations that will assist the Operator in the identification of the correct dual feed breaker (237-200-92-02901).

The Training Department will include a discussion of this event in the next upcoming Operator continuing training cycle. Additionally, the Training Department will poll the Non-licensed Operator Group to determine their knowledge level of the theory and application of alternate power supplies. A Training Request/Revision From has been submitted to conduct this discussion and determine the knowledge level of the Non-licensed Operator Group concerning alternate power feeds (237-200-92-02902).

The Training Department issued a Training Request/Revision (Number 0-92-0136) to revise the training lesson plan NLO-I (Non-Licensed Operator Initial Training). The Training Request will add information concerning electrical feeds to equipment including alternate feeds and emphasize the Unit to Unit inter-relationships (237-200-92-02903).

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The Maintenance Department Staff will revise procedure DEP 0040-10 (Votes System Operating Procedure) to clearly identify the electrical feed breaker to be operated during diagnostic testing of a Motor Operated Valve. The method currently under consideration is the use of a magnetic sign to be placed of the breaker cubicle during diagnostic testing (237-200-92-02904).

F. PREVIOUS OCCURRENCES:

Non-Reportable Title
Event

12-2-86-073 Inadvertent Loss of Power to M02-1301-4 Valve Due to Personnel Error.

The breaker for M02-1301-4 valve was inadvertently racked out by an Operator who intended to rackout the alternate feed for the M03-1301-4 valve. The breakers for both valves are located on Motor Control Center 28-1. M02-1301-4 was de-energized in the normal open position. The breaker was returned to normal after the Unit 2 Nuclear Station Operator observed the valve position indication was lost in the Control Room. The breaker for M03-1301-4 was not labeled at the time of this event because it was being installed under Modification M12-3-83-023 and was not in service at the time. Labels were placed on the breaker and the Operator along with the Unit Supervisor were reminded of the importance in correctly taking equipment out-of-service.

G. COMPONENT FAILURE DATA:

This section is not applicable because no component failure occurred.